MONTANA LEGISLATIVE HISTORY

Chapter 235 ~~19~~ 2001

Bill H _____ S 321 Original bill & history ____C

H. Committee on Human Services		S. Committee on Business & Labor	
Hearing Date(s) 3-19	✓ C	Hearing Date(s) 2-9	✓ C
_____	____C	_____	____C
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_____	____C	_____	____C
Date Out _____	____C		

Did this bill originate in an interim committee? ____Yes ____No

Committee _____ Report _____

HEARING ON SB 321

Sponsor: **SENATOR DALE MAHLUM, SD 35, MISSOULA**

Proponents: **Richard Smith, Physical Therapist**
Gary Lusin, Physical Therapist
Sami Butler, Montana Nurses Association
Mona Jamison, Montana Physical Therapy Association
SENATOR VICKI COCCHIARELLA, SD 32, MISSOULA

Opponents: None

Opening Statement by Sponsor:

{Tape : 1; Side : A; Approx. Time Counter : 0.6}

SENATOR DALE MAHLUM, SD 35, MISSOULA, said this bill would add physical therapists to the agencies that can provide full freedom of choice.

Proponents' Testimony:

Richard Smith, Physical Therapist, said this bill addresses freedom of choice by patients for physical therapists. He said the cost would be less for patients if they could choose their own physical therapists, rather than having to go to an M.D. to get a referral. **EXHIBIT(bus33a01)**

Gary Lusin, Physical Therapist, said there are two issues to this bill. One from the patients stand point would allow them to choose their own physical therapist. The other view point is from the business owners who find those patients that have direct access are hassle free. However those insurance companies which do not allow direct access cause the business owners to spend a great deal of time on the phone with insurance companies, patients and physicians trying to organize the whole process. **EXHIBIT(bus33a02)**

Sami Butler, Montana Nurses Association, said they support the bill.

Mona Jamison, Montana Physical Therapy Association, said there are insurance companies who don't think this is the law and this bill would make that clear. She said this would save the health care industry money by alleviating calls and doctor visits that are unnecessary.

APTA
American Physical Therapy Association

Montana Chapter

EXHIBIT NO. 1
DATE 2-9-2001
BILL NO. SB 321

TO: SENATE BUSINESS AND LABOR COMMITTEE:
Mike Taylor, Mike Sprague, Dale Berry, Edward Butcher, Vicki Cocchiarella, Sam Kitzenberg, Glenn Rousch, Don Ryan

FROM: Richard L. Smith, PT, President MAPTA

RE: SB 321 Freedom of Choice

DATE: 2/9/01

On behalf of the 360 members of the Montana Chapter APTA, I am asking for your support of **SB 321, a bill to allow freedom of choice by a patient in selecting his or her physical therapist** when seeking PT services covered under their insurance policy.

Although our Physical Therapy Practice Act allows us to see patients without a physician referral, numerous insurance companies do not cover the treatment, in spite of it being a covered service in their policy. SB 321 will assure statutory compliance and increased access to physical therapy care.

An excellent study completed by Blue Cross Blue Shield of Maryland in the 1990's showed that direct access episodes were shorter and were less costly than those classified as physician referral episodes. In other words, **direct access physical therapy is highly cost effective, but patients need true direct access to physical therapists.**

Please support SB 321 for Montana citizens. Thank you for your consideration.

cc: Mona Jamison
Senator Dale Mahlum

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Research Report

A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy

Background and Purpose. Access to physical therapy in many states is contingent on prescription or referral by a physician. Other states have enacted direct access legislation enabling consumers to obtain physical therapy without a physician referral. Critics of direct access cite potential overutilization of services, increased costs, and inappropriate care. Methods and Results. Using paid claims data for the period 1989 to 1993 from Blue Cross-Blue Shield of Maryland, a direct access state, we compiled episodes of physical therapy for acute musculoskeletal disorders and categorized them as direct access (n=252) or physician referral (n=353) using algorithms devised by a clinician advisory panel. Relative to physician referral episodes, direct access episodes encompassed fewer numbers of services (7.6 versus 12.2 physical therapy office visits) and substantially less cost ($1,004 versus $2,236). Conclusion and Discussion. Direct access episodes were shorter, encompassed fewer numbers of services, and were less costly than those classified as physician referral episodes. There are several potential reasons why this may be the case, such as lower severity of the patient's condition, overutilization of services by physicians, and underutilization of services by physical therapists. Concern that direct access will result in overutilization of services or will increase costs appears to be unwarranted. [Mitchell JM, de Lissovoy G. A comparison of resource use and cost in direct access versus physician referral episodes of physical therapy. *Phys Ther.* 1997;77:10–18.]

Key Words: *Direct access, Episode of care, Physical therapy, Physician referral.*

Jean M Mitchell

Gregory de Lissovoy

In many states, the practice of physical therapy is contingent on the prescription or referral by a physician, a requirement that effectively limits access to physical therapy services. Other states have enacted legislation permitting direct access—the ability of a health care consumer to freely visit a physical therapist without first securing referral from a physician. In these states, licensed therapists may evaluate patients without referrals and make autonomous decisions about subsequent clinical management.[1]

Although direct access in the United States dates back to 1957, the majority of states with direct access statutes have permitted physical therapists to treat and evaluate patients without physician referral only since the 1980s.[2] No published research has evaluated the impact of physician referral versus direct access on utilization and costs of care for persons undergoing physical therapy. This exploratory study compared the utilization of health care resources and third-party medical expenditures for persons receiving physical therapy under direct access versus those referred for such services by a physician.

We begin this report by providing some background on direct access to physical therapy. Next, we describe a study method based on the analysis of episodes of physical therapy created using Blue Cross-Blue Shield claims data. The final section discusses empirical results, study limitations, and implications for public policy.

Background

Thirty states allow physical therapists to treat and evaluate patients without physician referral, and an additional 14 states allow physical therapists to evaluate, but not treat, patients without referral.[2] Twenty states and the District of Columbia require physician referral as a prerequisite for treatment by a physical therapist.[1]

Advocates for physical therapists to have direct access argue that direct access extends consumers' choice of health care providers, improves access to services that promote prevention and rehabilitation, and reduces delays before commencing therapy. Proponents further argue that direct access may result in cost savings by avoiding the referring physician's fees and related ancillary services (eg, roentgenograms, laboratory tests). Supporters of direct access also point out that other nonphysician providers, such as chiropractors and clinical psychologists, do not require physician referrals or screening evaluations.[1,3]

Critics of direct access argue that physical therapists may overlook serious medical conditions and for this reason contend that all patients should be screened initially by physicians.[1,3] The American Medical Association (AMA) contends that although allied health care professionals are useful as physician extenders, they would not serve the public as well in an autonomous role.[4] The AMA and the American Academy of Orthopaedic Surgeons oppose independent practitioner status for physical ther-

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apists because of concerns about improper diagnosis, inappropriate care, and the potential for increased costs.[5] State medical societies and chiropractic groups have also been major adversaries of direct access. A common concern is that direct access legislation may lead therapists to diagnose and treat beyond their level of competency, thus erroneously assuming the role of physician.[6,7]

Previous research on direct access to physical therapy has considered the incidence of direct access practice,[1,8,9] patient and provider satisfaction with physical therapy received under direct access,[2,10] and physical therapist and patient opinions about direct access to physical therapy.[11–13] The limited available evidence from these published studies indicates that direct access has had only a minimal impact on physical therapy practice.[1,8–10] In some of these studies,[1,10] however, physical therapists expressed greater job satisfaction and patients preferred the more expeditious treatment received.[1,10]

Method

The Data

The study is based on health insurance claims data furnished by Blue Cross-Blue Shield of Maryland. This insurer has been reimbursing for physical therapy provided under direct access since 1986, so the coverage is well established. Group insurance paid claims represent a broad cross section of the employed population and their dependents. Because these individuals obtained health insurance through employer-sponsored plans, the effect of adverse selection, which characterizes persons with individual policies (or no insurance), is minimized. Although the data encompassed a number of different employer groups, the range of services covered and the level of reimbursement among groups in the sample were virtually identical. The plans covered only working-age adults and their children; persons eligible for Medicare (age 65 years and over) were not examined.

The data set included all paid claims for the calendar years 1989 through mid-1993. The initial file contained 1.7 million claims in four categories: professional fees, outpatient services (ie, radiology, laboratory, and ancillary services), prescription drugs, and hospitalization. Each record contained a unique beneficiary identification number, date of service, type of service, submitted charge, amount reimbursed by Blue Cross-Blue Shield, and subscriber copayment amount. Claims for professional services also included a designation of clinical specialty (eg, licensed physical therapist, orthopedic physician, chiropractor), Current Procedural Terminology (CPT) code for type of service, and ICD-9-CM (*International Classification of Diseases, 9th Revision, Clinical Modification*) diagnostic code for the condition.

Analytical Framework—Episodes of Physical Therapy

Health insurance claim files comprise a series of discrete transactions that document beneficiary encounters with the medical care system. Claims records can be grouped sequentially to construct "episodes of care" that encompass a series of temporally contiguous health care services related to treatment of a specific illness or health condition.[14] Recent studies have used the episodes framework to examine the decision to seek medical care, subsequent utilization of services, and expenditures.[14–20]

The main advantage of using claims data for health services research is that observations on a large number of individuals over an extended period of time can be obtained at relatively low cost. When compared with audits of medical records, this method for assessing medical care has limitations. First, only sparse information is available for each encounter, and this information has been collected for administrative rather than clinical purposes. Second, the validity of episode construction is contingent on algorithms created by the investigator. Error may arise from either the inclusion of irrelevant transactions or the exclusion of transactions actually related to the condition of interest. Third, a subject's health history and clinical status at the start of an episode must be inferred from the pattern of prior claims. Similarly, outcome of treatment following an episode must also be deduced from the presence (or absence) of subsequent claims. Finally, medical expenditures paid directly by the patient, such as charges for over-the-counter drugs, are not documented (although this is also true of medical records).

Episodes of physical therapy were constructed with guidance from an advisory panel of five licensed health care professionals practicing in Maryland. Panel members were selected from a list of candidates provided by the Maryland Physical Therapy Association in response to a request for names of active practitioners specializing in physical therapy and orthopedic medicine. The panel consisted of three physical therapists and two physicians (an orthopedic surgeon and a physical medicine/rehabilitation specialist). Additional insight on the idiosyncracies of the claims data was provided by the medical director of Maryland Blue Cross-Blue Shield. Panel functions were to develop criteria for constructing episodes of care and to establish rules for classifying episodes as either direct access or physician referral.

An episode of physical therapy should encompass all services provided in relation to a specific illness or condition during a suitable time period.[14] At the time of this study, physical therapy performed by a licensed

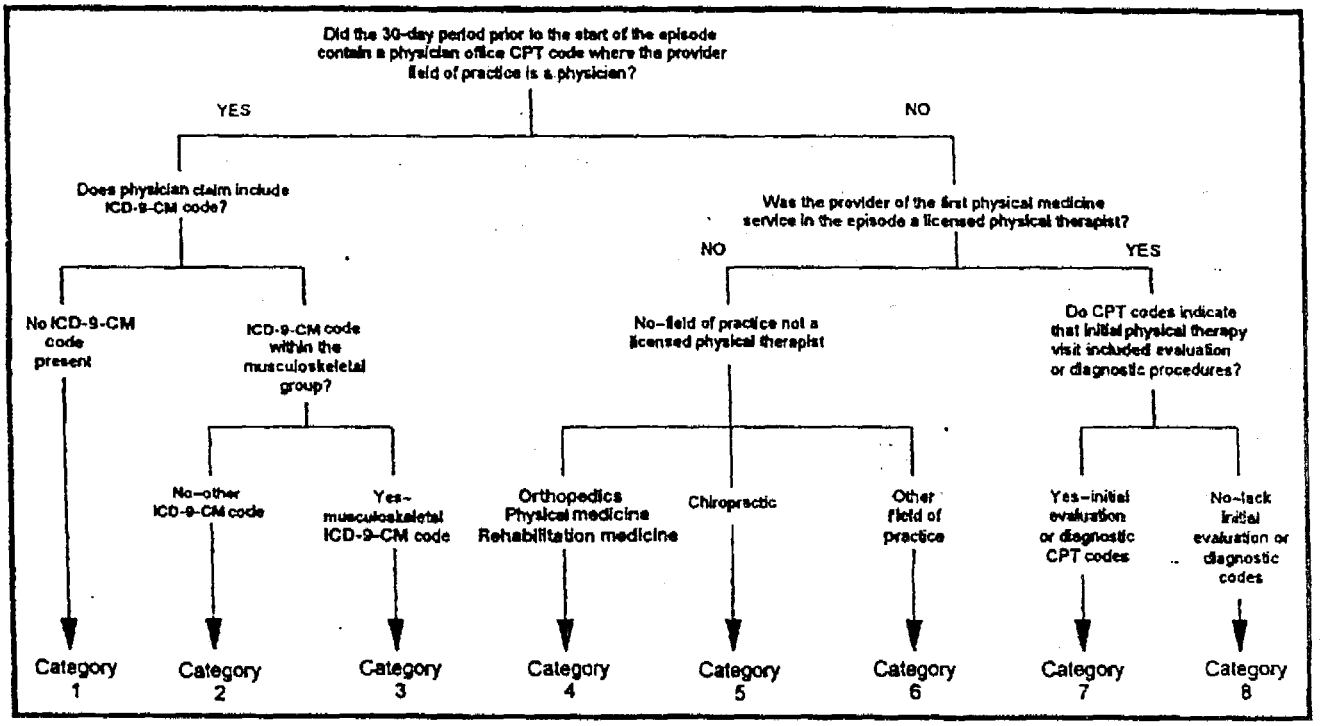
Did the 30-day period prior to the start of the episode contain a physician office CPT code where the provider field of practice is a physician?
YES
NO
Does physician claim include ICD-9-CM code?
Was the provider of the first physical medicine service in the episode a licensed physical therapist?
NO
YES
No ICD-9-CM code present
ICD-9-CM code within the musculoskeletal group?
No–field of practice not a licensed physical therapist
Do CPT codes indicate that initial physical therapy visit included evaluation or diagnostic procedures?
No–other ICD-9-CM code
Yes–musculoskeletal ICD-9-CM code
Orthopedics Physical medicine Rehabilitation medicine
Chiropractic
Other field of practice
Yes–initial evaluation or diagnostic CPT codes
No–lack initial evaluation or diagnostic codes
Category 1
Category 2
Category 3
Category 4
Category 5
Category 6
Category 7
Category 8

Figure.
Algorithm for categorization of episodes of care (CPT=Current Procedural Terminology, ICD-9-CM=*International Classification of Diseases, 9th Revision, Clinical Modification*). Note: musculoskeletal ICD-9-CM codes include 710–739 and 840–848.

physical therapist was billed under "physical medicine" procedure (CPT) codes. Other health care professionals such as physicians and chiropractors also utilize these CPT codes for services performed, even though they are not licensed physical therapists and thus may not be performing identical services. For purposes of classification, we refer to episodes of care defined by physical medicine procedures as physical therapy, irrespective of the health care provider who rendered the service.

We first identified all individuals who had at least one physical therapy claim during period January 1990 through December 1991. Approximately 11,600 individuals met this criterion. We then sorted each individual's claims for the period 1989 through 1993 in chronological order by date of service and created a window of observation extending from 12 months prior to the date of the first physical therapy service to 12 months after the last physical therapy service. This window contained all or part of one or more episodes of care.

Criteria for marking an episode's beginning and end points were devised by the advisory panel. We examined the 30-day period prior to the first physical therapy claim that occurred during the period January 1990 through December 1991. If no physical therapy claim occurred during the 30 days preceding the first physical therapy service, this date marked the beginning of an episode of care. If a physical therapy claim did occur within that 30-day period, the next 30-day period prior to that claim was reviewed. This process was repeated for each preceding 30-day period until reaching the initial transaction in the data set (January 1, 1989).

We then identified the last physical therapy service that occurred during the period January 1990 through December 1991. The panel recommended examining a 45-day period subsequent to this encounter. If no physical therapy claims were recorded during this 45-day period, then the last physical therapy service marked the end of the last episode. Alternatively, if a physical therapy service was recorded during this subsequent 45 days, the episode was deemed incomplete and the next 45-day period following the physical therapy service was examined. Again, this procedure was repeated until reaching the end of the data set (December 31, 1992). Using this approach, we created a new file containing observations on approximately 3,500 persons who had at least one episode of physical therapy that began and ended during the period 1989 through 1992.

These beginning and end points could actually mark different episodes. For this reason, we next examined the 45-day period occurring after the date established as the commencement point of the episode denoted by the first physical therapy service in order to distinguish among multiple episodes. If a physical therapy encounter occurred within 45 days after the commencement of

Table 1.
Comparison of Mean Values for Resource Utilization and Cost in Direct Access Episodes Versus Physician Referral Episodes

Variable	Direct Access (n=252)	Physician Referral (n=353)	Difference*
Physical therapy claims	20.2 (82.9)	33.6 (39.0)	13.4
Physical therapy office visits	7.6 (9.1)	12.2 (12.8)	4.6
Physical therapy claims paid ($)	566 (716)	890 (941)	324
Drug claims	1.47 (4.0)	3.13 (7.72)	1.66
Drug claims paid ($)	36 (109)	78 (223)	42
Radiology claims	0.32 (1.03)	1.02 (1.86)	0.70
Radiology claims paid ($)	44 (190)	175 (541)	131
Hospital admissions	0.25 (0.80)	0.64 (1.17)	0.39
Hospital admissions paid ($)	83 (402)	397 (1,003)	315
Total claims paid ($)	1,004 (2,030)	2,236 (2,827)	1,232

* $P < .01$.

an episode, the two encounters were considered part of a single episode. This procedure was repeated for all subsequent physical therapy services. If a period of 45 days occurred in which there was no physical therapy service, then the date of the last physical therapy service prior to the 45 days in which no physical therapy services were rendered marked the end of the episode. If another physical therapy service was observed beyond this 45-day posttreatment period, then this date marked the commencement point of another episode.

Classification of Episodes

After creating episodes of physical therapy, the next task was to classify episodes as either direct access or physician referral. Because claims data do not differentiate direct access episodes from those that were referred, we adopted decision rules recommended by the advisory panel. The classification algorithm, depicted in the Figure, differentiated eight categories of episodes.

We first examined the 30-day period prior to the first physical therapy service within each episode to determine whether there was a claim for a physician service with either ICD-9-CM codes or CPT codes indicating a condition that could reasonably lead to the provision of physical therapy. The panel recommended a focus on only acute and sporadic musculoskeletal-related disorders (ICD-9-CM codes 710–739 and 840–848). The 30-day period was deemed conservative because a typical person receiving a prescription for physical therapy could likely schedule an initial appointment within 2 weeks. We then determined whether claims for physical therapy services within the episode were rendered by a licensed physical therapist in order to exclude physical therapy services rendered by other providers (eg, chiropractors). If these criteria were met, the episode was classified as a physician referral (category 3).

Episodes for which there was no indication that a physician encounter occurred in the 30-day period preceding the first physical therapy service were then examined to determine whether services were provided by a licensed physical therapist. Category 7 contained episodes in which claims for diagnostic or evaluation procedures were recorded for the first encounter with the physical therapist. Criteria for category 8 were identical to those for category 7 except that no initial claims for diagnostic evaluation were observed. Categories 7 and 8 were grouped together and comprise the direct access episodes. Other categories (1, 2, 4, 5, and 6) did not meet the criteria for either direct access or physician referral and were excluded from the analysis.

We then visually inspected the set of transactions comprising episodes in categories 3, 7, and 8. Following recommendations of the advisory panel, we excluded episodes that involved claims for chronic musculoskeletal conditions (eg, arthritis, cancer, multiple sclerosis, osteoporosis). We also excluded episodes in which the patient appeared to have multiple comorbidities. These episodes tended to contain visits to a number of different providers for a range of health problems, making it impossible to determine whether physical therapy received by the patient represented treatment for the initial encounter with a musculoskeletal diagnosis. The final analysis file comprised 252 direct access and 353 physician referral episodes.

Statistical Analyses

We first compared the mean values of utilization and cost variables for direct access versus physician referral episodes using a two-tailed test for differences between means, with a null hypothesis of no difference (Tab. 1). Because simple comparisons do not control for confounding factors, we also used multiple regression analysis to compare direct access and physician referral episodes with respect to utilization (number of physical therapy visits) and costs. Definitions of variables used in the analysis are presented in Table 2. Summary statistics for the dependent and explanatory variables follow each definition.

Table 2.
Definitions of Variables Used in Regression Analyses

Variable	Definition
Dependent	
Logarithm-physical therapy visits	Natural logarithm of the count of physical therapy office visits during the episode ($\bar{X}$=1.78, SD=1.12)
Logarithm-physical therapy paid	Natural logarithm of total dollar amount reimbursed by Blue Cross-Blue Shield for physical therapy services received by patient during the episode ($\bar{X}$=6.03, SD=1.26)
Logarithm-total paid	Natural logarithm of total dollar amount reimbursed by Blue Cross-Blue Shield for all services received by patient during the physical therapy episode ($\bar{X}$=6.61, SD=1.48)
Independent	
Direct access	Dichotomous variable: 1 if episode was direct access (category 7 or 8), 0 if episode was physician referral (category 3) ($\bar{X}$=0.58, SD=0.49)
Female	Dichotomous variable: 1 if the beneficiary gender was female, 0 if male ($\bar{X}$=0.63, SD=0.48)
Age	Beneficiary age (in years) ($\bar{X}$=42.19, SD=12.5)
Drugs	Dichotomous variable: 1 if the episode contained any claims for prescription drugs, 0 if otherwise ($\bar{X}$=0.42, SD=0.49)
Hospital	Dichotomous variable: 1 if the episode contained any claims for inpatient or outpatient services provided by an acute care general hospital, 0 if otherwise ($\bar{X}$=0.25, SD=0.44)
Radiology	Dichotomous variable: 1 if the episode contained any claims for diagnostic radiology services provided by a physician or freestanding imaging center, 0 if otherwise ($\bar{X}$=0.29, SD=0.46)
Direct access-drugs	Interaction of "direct access" and "drugs": 1 if a direct access episode contained prescription drug claims; 0 if otherwise ($\bar{X}$=0.12, SD=0.32)
Direct access-hospital	Interaction of "direct access" and "hospital": 1 if a direct access episode contained claims for hospital services; 0 if otherwise ($\bar{X}$=0.55, SD=0.23)
Direct access-radiology	Interaction of "direct access" and "radiology": 1 if a direct access episode contained diagnostic radiology claims performed at a physician office or freestanding imaging center, 0 if otherwise ($\bar{X}$=0.55, SD=0.23)

The total cost of each episode of physical therapy was computed as the sum of all paid claims for services and drugs provided during the episode. A logarithmic transformation was performed on the dependent variables to adjust for observed right-skewed distribution, which is typical of medical utilization and expenditure data.[21] The primary explanatory variable of interest was referral status. The dichotomous variable "direct access" identified episodes in categories 7 and 8 while category 3 (physician referral) served as the reference category. Three dichotomous variables were constructed to identify episodes that contained any claims for hospital services (hospital), pharmaceuticals (drugs), and diagnostic imaging rendered via a physician's office or freestanding center (radiology). All three categories of service must be prescribed by a physician and thus suggest greater severity of illness than episodes not including these services. To further distinguish episodes involving any or all of these services by referral status, we constructed interaction terms. These terms identified direct access episodes that involved claims for hospital services (direct access-hospital), pharmaceuticals (direct access-drugs), and imaging procedures (direct access-radiology). Additional variables controlled for age and gender.

Results

Table 1 shows simple comparisons using tests for differences between means. Physician referral episodes were characterized by 13.4 (67%) more physical therapy claims and 4.6 (60%) more office visits than direct access episodes ($P<.0001$). Reimbursements for physical therapy services were, on average, $324 (57%) more expensive for physician referral episodes when compared with direct access episodes ($P<.0001$). Total paid claims averaged $2,236 for physician referral episodes and $1,004 for direct access episodes; this $1,232 difference signifies that the cost to Blue Cross-Blue Shield for physician referral episodes exceeded the cost for direct access episodes by about 123% ($P<.001$).

Table 3 displays the results of regressions where the dependent variables were the number of physical therapy visits, paid claims for physical therapy services, and total paid claims for all services and drugs. In each case, the dependent variable has been transformed and is expressed as its natural logarithm. Adjusted multiple regression (R^2) values indicate that models account for about 25% of the variation in the logarithm of physical therapy visits and for about 21% for the logarithm of physical therapy claims. The regression explains 48% of

Table 3.
Regression Estimates for Number of Physical Therapy Visits, Paid Claims for Physical Therapy Services, and Paid Claims for All Services[a]

Independent Variable	Number of Physical Therapy Visits (Log)	Paid Claims for Physical Therapy Services (Log)	Total Paid Claims for All Services and Drugs (Log)
Direct access[b]	−0.503**	−0.519**	−0.864**
	(0.111)	(0.134)	(0.125)
Drugs	0.361**	0.346**	0.425**
	(0.10488)	(0.124)	(0.116)
Hospital	0.268*	0.274*	0.934**
	(0.121)	(0.142)	(0.134)
Radiology	0.479**	0.534**	0.853**
	(0.117)	(0.138)	(0.130)
Direct access-hospital[c]	0.127	0.106	0.133
	(0.251)	(0.295)	(0.269)
Direct access-drugs[c]	0.601**	0.644*	0.685**
	(0.178)	(0.210)	(0.198)
Direct access-radiology[c]	−0.298	−0.107	0.249
	(0.248)	(0.292)	(0.272)
Female[b]	0.112	0.161	0.149
	(0.083)	(0.098)	(0.092)
Age	−5.643	−0.002	−0.002
	(0.003)	(0.004)	(0.004)
Constant[c]	1.504**	5.756**	6.191**
	(0.155)	(0.184)	(0.173)
Adjusted R^2	.247	.212	.479
F statistic	22.94	17.34	61.79

[a] Standard errors of regression coefficients are in parentheses. Single asterisk (*) indicates $P < .05$, double asterisk (**) indicates $P < .01$.
[b] Reference category for "direct access" is "physician referral"; reference category for "female" is "male."
[c] Interaction term between "direct access" and named variable.

Table 4.
Percentage of Difference in Utilization and Cost for Direct Access Episodes Relative to Physician Referral Episodes[a]

Model Dependent Variable	Difference Relative to Physician Referral Episode
Number of physical therapy visits	−65%
Paid claims for physical therapy services	−68%
Total paid claims for all services and drugs	−137%

[a] Based on regression results shown in Table 3.

the variation in total paid claims for all services and drugs.

In each model, the coefficient for the variable "direct access" was negative ($P<.01$), implying that episodes of physical therapy classified as direct access involved fewer visits and lower costs relative to episodes classified as physician referral. Coefficients for the variables identifying episodes of physical therapy that included claims for drugs, hospitalizations, or radiology were positive and significant at $P<.01$. These findings imply that physician referral episodes with claims for any or all of these services are characterized by more physical therapy visits, higher paid claims for physical therapy services, and higher total costs per episode relative to physician referral episodes that do not involve drugs, hospitalizations, or imaging procedures.

Interaction terms that identified direct access episodes involving hospital inpatient services or imaging were not significant, implying that such services have little bearing on use of physical therapy or episode costs. By contrast, direct access episodes that contained one or more claims for pharmaceuticals were associated with more physical therapy visits, higher paid claims for physical therapy, and higher total episode costs. The variables controlling for gender and age had negligible effects on both utilization and costs.

Because log-transformed results cannot be interpreted directly, the coefficients for the direct access variables have been converted to percentages (Tab. 4). Relative to physician referral episodes, those episodes classified as direct access involved 65% fewer physical therapy visits and 68% lower paid claims for physical therapy services.

The lower utilization rates for all services that characterized direct access episodes is best seen by examining total episode costs. When measured in terms of paid claims, direct access episodes were 137% less expensive than those classified as physician referral.

Discussion

Thirty states have legislation enabling patients to obtain physical therapy services without physician referral (direct access). The public policy objective for direct access statutes is to give the consumer the ability to select the most appropriate source of care. Consumers, however, should be protected against underprovision of care that could occur if physician services were not provided when medically necessary.

Using Blue Cross-Blue Shield claims data from Maryland (a state with direct access statutes), we compared episodes of physical therapy categorized as direct access relative to those classed as physician referral and found substantial differences. Direct access episodes were shorter, encompassed fewer numbers of services, and were less costly than those classed as physician referral. Some direct access episodes included claims for inpatient hospital care, drugs, or outpatient radiology—all services requiring physician prescription. The use of hospital services or imaging procedures during direct access episodes had a negligible relationship with the number of physical therapy visits or episode costs. In contrast, direct access episodes that contained claims for drugs were associated with greater use of physical therapy and higher costs. Physician referral episodes that included any or all of these three items were associated with higher utilization and costs.

Because our study was based on health insurance claims data, these findings must be interpreted with caution. The method relied on sorting algorithms to identify episodes of care and to distinguish direct access from physician referral. We cannot be certain that resource use attributed to episodes and their classification accurately identified each patient's course of therapy. In addition, we have no way of knowing whether the lower cost of direct access episodes was due to underprovision of care or whether the greater resource intensity and cost of physician referral episodes reflects overprovision of care.

Conclusions

We conclude that direct access episodes, on average, are short in duration and relatively inexpensive. Potential explanations why this may be the case include lower severity of the patient's condition, overutilization of services by physicians, and underutilization of services by physical therapists. Concern that direct access will result in overutilization of services or will increase costs appears unwarranted. The fact that some direct access episodes included physician-prescribed services indicates that physical therapists are making referrals to physicians. Thus, our study offers evidence that public policy objectives for direct access to physical therapy services are being achieved.

Acknowledgments

We acknowledge the invaluable guidance provided by advisory panel members Richard Hinton, MD, Cindy Juris, MD, Annette Iglarsh, PhD, PT, Rod Schlegel, PT, and Mark Valente, PT. Insight on use of Maryland Blue Cross-Blue Shield claims data was provided by Alan Wright, MD. Chuanfa Guo provided expert computer programming in construction of episode-of-care files. Emily Tobias Shumsky assisted in the detailed inspection of final-analysis files. Comments on an earlier version of this manuscript were provided by Jack Hadley, Vivian Hamilton, and Robert Hurley.

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SENATOR VICKI COCCHIARELLA, SD 32, MISSOULA, said she has seen the costs added to claims by having to go to an M.D., and she wholeheartedly supports this bill.

Opponents' Testimony: None

Questions from Committee Members and Responses: None

Closing by Sponsor:

{Tape : 1; Side : A; Approx. Time Counter : 10.9}

Senator Dale Mahlum, SD 35, Missoula, closed without comment.

EXECUTIVE ACTION ON SB 321

Motion/Vote: **SEN. MAHLUM** moved that **SB 321 DO PASS. Motion carried unanimously.**

HEARING ON HB 154

Sponsor: **REPRESENTATIVE DANIEL MCGEE, HD 21, LAUREL**

Proponents: **Gary Gilmore, Depart of Transportation**
Linda Stahl, Montana Association of Planners

Opponents: None

Opening Statement by Sponsor:

{Tape : 1; Side : A; Approx. Time Counter : 12.9}

REPRESENTATIVE DANIEL MCGEE, HD 21, LAUREL, said basically this bill strikes the requirement that you be within 3 miles of a control point in order to get a coordinate in surveying.

Proponents' Testimony:

Gary Gilmore, Depart of Transportation, said the benefits of this bill would be significant to the department in that it would facilitate the use of new technology.

Executive Action: SB 311, SB 321, SB 310, SB 207, SB 181

HEARING ON SB 321

Sponsor: **SEN. DALE MAHLUM, SD 35, Missoula**

Proponents: **Gary Lusin, Bozeman, Mt. Chapter of the American Physical Therapy Assn.**
Gail Wheatley, Great Falls
Kirk Hanson, Helena
Jim McLean, Frenchtown
Sami Butler, Mt. Nurses' Assn.
Mona Jamison, lobbyist, Mt. Chapter of the American Physical Therapy Assn.

Opponents: None

Opening Statement by Sponsor:

SEN. DALE MAHLUM, SD 35, Missoula, said this bill does something that should have happened some time ago but it just didn't get done. It's the freedom to choose for licensed physical therapy and it's really good for the people of our state because they don't have to find a doctor first to give them a prescription to go to a physical therapist. *{Tape : 1; Side : A; Approx. Time Counter : 0 - 2.7}*

Proponents' Testimony:

Gary Lusin, Bozeman, Mt. Chapter of the American Physical Therapy Assn., said his chapter has over 400 members across the state. In 1987 they pursued direct access, which the legislature passed, and they've been operating well since then from a clinical standpoint. Soon after that, Blue Cross/Blue Shield changed their policy to allow their insured to receive services from physical therapists without physician referral, and they paid for that accordingly. Since then, a few other insurances have followed suit, but there are many insurers at this point that do not honor the statute. This creates hassles for therapists and patients as well as the physicians or anyone involved in the patients' care. This bill would clarify that and amend the insurance statutes to make it clear that when policies cover physical therapy services, the individual has the freedom of choice to select a therapist, go to

that therapist without physician referral and have those services covered according to their policy. They encourage support of the bill. **EXHIBIT(huh62a02)** ***{Tape : 1; Side : A; Approx. Time Counter : 2.7 - 4.4}***

Gail Wheatley, Great Falls, physical therapist, said she had worked in Fort Benton for over seven years and most of the time a primary care physician was not in Fort Benton but in Great Falls, All the speciality care was in Great Falls. This bill would be an enormous bonus to the people in a rural community who don't have easy access to their physicians and would have some difficulty going into Great Falls and making appointments for services that are not always necessary and not required by state law. She thinks this would be very helpful for some of those small communities. There is already a law on the books that allows anyone to go to a physical therapist without physician referral, so that does not change. This does not require an insurance company to pay one dime more than they already are. These are for covered services. It doesn't change or enlarge her scope of practice in any way. It only says if you cover physical therapy services, you will pay for them, and it gives patients an assurance of reimbursement, just like when they choose their chiropractor, their psychologist or their acupuncturist now, they can choose their physical therapist and know that they will be reimbursed for that. ***{Tape : 1; Side : A; Approx. Time Counter : 4.4 - 6.2}***

Kirk Hanson, Helena, physical therapist, requested support for the bill. He thinks it would be helpful to people seeking physical therapy because they could get it sooner, without having to wait for approval from an insurance company or to wait to see another practitioner such as a physician for a referral. ***{Tape : 1; Side : A; Approx. Time Counter : 6.2 - 7}***

Jim McLean, Frenchtown, physical therapist, encouraged the committee to support the bill because it will save consumers money. Often they go to a doctor simply to get a prescription when they know they need physical therapy, so they have an extra doctor's visit that may not be necessary. Secondly, a number of studies have shown that the earlier you go to physical therapy, the shorter the course of treatment and the cheaper it is. ***{Tape : 1; Side : A; Approx. Time Counter : 7 - 7.4}***

Sami Butler, Mt. Nurses' Assn., said that nurses are advocates for access to health care and also freedom of choice of providers. They believe that this bill supports this concept, and it looks like it is going to decrease costs and they're all for that.

Mona Jamison, lobbyist for the Mt. Chapter of the American Physical Therapy Assn., said that in 1987 when they drafted their bill for direct access, they didn't get the job totally done. They amended section 37-11-104 in the Mt. Physical Therapy Practice Act, where it made it quite clear in (3) that evaluation and treatment provided by physical therapists could be done without a referral from a physician. Blue Cross/Blue Shield honored that provision, as did other insurers. It saved money and provided quicker physical therapy services to those in need. Unfortunately, not all of the insurers complied, and the physical therapists think it is because they didn't go into the insurance code and make it clear in that code also that you did not need a prescription before you went to see a physical therapist. In Section 1 of this bill, 33-22-111 is being amended where physical therapists are being added to a list that's already provided which allows consumers/patients to choose a physical therapist without a referral. That's direct access. That's the insurance code direct access provision. Section 2 applies to health service corporations, and although the Blues have complied with that, and it's important that that be recognized, the physical therapists felt that in terms of equal drafting, they should make sure this time they get the job totally done. That's what this bill is about. If a person needs physical therapy services, they can choose their physical therapist and they can save the whole health care system dollars. The scope of practice is not changed in this bill and no benefit is created that may not already be provided. If there is a provision in someone's health insurance policy that physical therapy services are provided, the patient/consumer may choose a physical therapist and not wait for a referral from their physicians. **EXHIBIT(huh62a01)** ***{Tape : 1; Side : A; Approx. Time Counter : 7.4 - 12.1}***

Opponents' Testimony: None

Informational Testimony: None

Questions from Committee Members and Responses:

Rep. Noennig asked **Mona Jamison** to explain what section 2 of the bill does. **Ms. Jamison** said in working with the Legislative Council, they said the comparable section for health service corporations is the section that is drafted here. If you go into Title 33, chapter 30, part 10, you will see that other health care providers that are listed in section 1, which is what applies to the regular health insurance companies, have exact comparable sections as section 2 in the health service corporation law, but they were not consolidated into one section, they were all set out separately. The physical therapists were advised to do the same,

rather than start amending many sections. *{Tape : 1; Side : A; Approx. Time Counter : 12.1 - 14.1}*

Closing by Sponsor:

Sen. Mahlum said that this bill, although it's small in stature and doesn't say much, means a lot to the working people of Montana, because of the fact that if they do have a problem, they don't have to go to a regular physician and they can go to a physical therapist without a prescription and can get the work done quicker, go back to their family in better shape and go back to work. It makes it a lot better for the people of Montana. This is what we call direct access and it is cost effective. *{Tape : 1; Side : A; Approx. Time Counter : 14.1 - 18.1}*

HEARING ON SB 477

Sponsor: **SEN. GREG JERGESON, SD 46, Chinook**

Proponents: **Rose Hughes, Ex. Dir., Mt. Health Care Assn.**
Sen. Linda Nelson, SD 49, Medicine Lake
Lori Henderson, Havre
Evelyn Havskjold, Director, Area 10 Agency on Aging
Denzel Davis, Admin., Quality Assurance Div., DPHHS
Janet Thomas, Hobson
Jim Ahrens, Mt. Hospital Assn.
Phyllis Taylor, Lewistown
Bill McLean, nursing home owner

Opponents: **Betty Beverly, Ex. Dir., Mt. Sr. Citizens' Assn.**
John Kershaw, East Helena
Chuck Notbohm, Clancy, AARP
Anita Rossmann, Mt. Advocacy Program

Opening Statement by Sponsor:

SEN. GREG JERGESON, SD 46, Chinook, presented amendments to the bill. He said that the primary purpose of this bill was a subject that came from a number of discussions that legislators have had with providers of long-term nursing home care to families around the state. It came to have personal meaning to him. Over five and a half years ago, his dad had a severe stroke and on several different occasions, he had him cared for in a nursing home. One of the questions the family asked was about his safety in his bed and whether or not they would have things like side rails. They wanted to be assured that he would not roll from or fall from the bed and

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Exh 2
3/21/01
SB 321

TO: **HOUSE HUMAN SERVICES COMMITTEE** **3-19-01**

RE: **SB 321**

I am in full support of SB 321 and I urge your support as well.

I am a physical therapist and have been practicing in Bozeman since 1981. Over the years many changes have taken place within the health care system as well as a change in expectation of society regarding their access to services. SB 321 finalizes a process started in 1987 when the legislature granted individuals direct access to PT, without physician referral.

This process has worked very well, for those insurance's that acknowledged the change in law. Blue Cross/Blue Shield immediately allowed their insured direct access to PT services and I have heard of no problems with that policy since.

There are several insurance's that require a patient to have a physician referral before they will provide coverage for that patient. In addition the insurance may also require various levels of information from the patient, and from us, all of which presents unnecessary delay in the provision of services.

While patient access is the primary reason for this legislation, if passed, I will have a decrease in my costs to have my staff make numerous phone calls to the insurance, the physician, and the patient just to get all the paper work in order for the patient to begin treatment.

SB 321 **does not add cost** to the patient in need of PT. In fact studies have verified that in will **save patient's money.** However, if a patient goes to a PT, is examined, and found to require a physician visit based on their condition, they are immediately referred.

SB 321 does not expand or change the laws regarding PT practice. We will continue to practice as we have since direct access was established in 1987. This bill will, however, assure that patients who need and want PT services will be able to access a PT of their choice and know that it will be covered as their policy indicates, without the hassle's and delays currently encountered.

Gary Lusin, PT,MS,ATC,CSCS

Ex 1
3/19/01
SB321

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SB 321 - FACT SHEET

Freedom to Choose a Licensed Physical Therapist for Physical Therapy Services

In summary, SB 321 provides a patient freedom of choice in selection of their physical therapist when seeking physical therapy services covered under their insurance policy.

1. In 1987, section 37-11-104 of the Montana Physical Therapist Practice Act was amended to allow licensed physical therapists to perform the evaluation and treatment procedures authorized in their practice act without a referral. In other words, this "direct access" statute allows an individual to receive treatment from a licensed physical therapist without first having to see a physician in order to get a referral. **This is current Montana law**. (37-11-104, MCA)

2. SB 321 directly amends the insurance statutes to clearly require all disability insurance policies or certificates to provide that the insured has full freedom of choice in the selection of any licensed physical therapist for treatment of any illness or injury within the scope of physical therapy practice. SB 321 also makes certain that the freedom of choice in selection of a physical therapist applies to health service corporations. Where the 1987 "direct access" statute has not been followed by all insurers, SB 321 will assure statutory compliance and increased access to physical therapy care.

3. SB 321 does not add or require coverage for physical therapy services under any insurance policy nor does it enlarge or expand the scope of physical therapy practice as described in Title 37, Chapter 11, MCA. It simply provides an individual direct access and reimbursement for covered services provided by a licensed physical therapist. SB 321 also assures increased access to physical therapy services at lower cost in rural areas where physician services are not always available.

4. A recent study entitled A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy showed that direct access episodes were shorter, encompassed fewer numbers of services, and were less costly than those classified as physician referral episodes. (Physical Therapy, Vol 77, January 1997)

5. Physical therapy care is highly cost effective, particularly for decreasing disability from neurological disorders, chronic pain, arthritis, and low back pain. Assuring direct access to cost effective, less expensive physical therapy for Montana citizens will result in savings to the patient and the health care system..

PLEASE SUPPORT SB 321.

EXECUTIVE ACTION ON SB 321

Motion/Vote: **REP. SCHMIDT** moved that **SB 321 BE CONCURRED IN. Motion carried unanimously. Rep. Brown** will carry the bill. ***{Tape : 4; Side : A; Approx. Time Counter : 9.4 - 11.7}***

EXECUTIVE ACTION ON SB 310

Motion: **REP. SCHMIDT** moved that **SB 310 BE CONCURRED IN.**

Discussion: Discussion was held on the premium of one percent, as found on page 4. The sponsor had spoken about raising the premium, and this puts a cap on it but doesn't raise it. **Rep. Esp** asked **Rep. Facey** if the language on page 4, line 19 through 25 is the standard penalty language. He thought simpler wording would be a penalty of up to 1.5 percent per month not to exceed 18 percent and that would make more sense. He asked **Mr. Niss** about rewording the present language. **Mr. Niss** said a court's interpretation of the current language on lines 21, 23 and 25 would be that those three subdivisions, I, II and III, are all in the alternative. There are three alternatives there, not two. The reason for that exclusively is the use of the word "or" after the semi-colon on line 24. That is a very common bill-drafting technique, and the intent of that kind of a structure with the "or" only on line 24 is that it is interpreted as if there was also an "or" after the semi-colon on line 22. Further discussion was held on this section.

Motion: REP. SHOCKLEY moved **a conceptual amendment to SB 310 to strike lines 21 through 25 and substitute a concept that says the association shall impose a penalty not to exceed 1.5 percent per month. He would not put a cap on it of 18 percent.**

Discussion: **Rep. Lee** spoke against the amendment because by not spelling it out as clearly as the bill does and not allowing the flexibility to take a settlement less than the percentages made, the amendment wouldn't be doing what the bill is intended to do. **Rep. Raser** said she agreed with **Rep. Lee**, and we don't know what the sponsor intended with this. **Rep. Noennig** thinks the sponsor intended to delete a late payment penalty on lines 19 and 20 and to change line 25 to say both the charge in subsection 1 and the interest in subsection 2, so what it would really say is that you can charge 1-1/2 percent per month, not to exceed 18 percent, or you can charge interest at 12 percent a year, or you can charge